REPORT OF A CASE OF ILEUS CAUSED BY A UNIQUE ENTEROLITH.*

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Mrs. K., of Maysville, Ark., age 42, married, mother of several children, pregnant five months; patient of Dr. J. T. Powell.

Clinical history: Five or six days before my visit, Nov. 11, 1907, there had been diarrhea. During the last four days the bowels had not acted, notwithstanding enemas had been freely and frequently given. Frequent vomiting had characterized this period. The vomitus had been stercoraceous for forty-eight hours. Hyper-peristalsis, tympany, griping, tenderness, restlessness and rapid breathing were conspicuous. Temperature normal and pulse 110.

Considering the history and delay her condition was tolerably good. It is proper to state that this delay was not Dr. Powell's fault, for he had in due time urged resort to surgical means.

The ileum, that is the part that was easily accessible through the incision, was distended and much discolored. With part of the hand in the abdomen there was felt in the left iliac region a hard mass, which when brought into the incision was found to be in the ileum and very completely occluding its lumen.

Notwithstanding manipulations that were painstaking, the more so because of the distended and discolored conditions above the obstruction, the bowel ruptured before it could be aspirated. This wound in the intestine was sutured instead of being enlarged for the removal of the lith, because the latter was about ten inches below and so tight in the gut that it was not thought prudent to try to move it so far.

Perhaps it is proper to state that this rupture, though in part due to the friable and distended condition of the gut and to the pressure to which it was subjected in the incision by the underlying pregnant uterus, could possibly have been avoided by a larger incision. Be this as it may, barring the abortion that occurred on the second day and some infection, the patient made a slow but good recovery.

The enterolith was about the size of a small hen egg, but now, after shrinking, as you see, not half so large, and composed mainly of persimmons that had been eaten about two weeks before.

Investigation in the surgeon general's office fails to reveal another enterolith of which persimmons were a component part. Hence the term "unique enterolith" in the title of this paper.

The claim for uniqueness may be questioned by some of the members of this association, who two years ago heard me report a similar case and saw the lith. That one, like this, was composed mainly of persimmons, but was removed post-mortem from the stomach instead of the intestine—one a gastrolith, the other an enterolith.

The case of gastrolith above referred to has been recorded in the proceedings of the Arkansas Medical Society for 1900, and in Vol. IV of "Transactions of the Chicago Pathological Society," the concretion having been exhibited before the latter by Dr. M. Herzog, who made a brief report of it from notes I gave him.

In order that it may be recorded in medical literature more current than these, a brief synopsis is appended.

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In January, 1900, this gastrolith was removed postmorten from the 3-year-old son of Mr. J. W. Walker, who lives on Pea Ridge, in this State. I first saw the patient in my office about two weeks before his death, he having been referred to me by Dr. A. M. Gaines. The parents gave the following history: About nine weeks before, he vomited a quanity of persimmons, including many seeds. Every day afterwards until his death, he vomited more or less mucus, which usually contained small dark particles. A peculiarity of his vomiting was that frequently after swallowing once or twice at the beginning of a meal he usually ejected the food and some mucus, after which he would finish the meal with but little difficulty. His appetite was good, sleep sound, bowels regular and flesh not reduced. Indeed he was a healthy-looking child. Dr. Gaines had discovered a hard mass, the lower end of which occupied the epigastrium. The other extended obliquely upward and to the left, and so far under the costal cartilages that it could not be reached, even by much manipulation.

The next examination, made three days before the child's death, revealed nothing new, but caused me to repeat my former advice to have an early exploratory incision and gastrotomy, if found necessary. The parents indicated that they expected to act on my advice, but deferred for a few days.

Three days later Dr. Gaines telephoned me to meet him in consultation. His description of symptoms left little doubt that peritonitis had supervened. The child died before my arrival. Eighteen hours before death perforation had occurred, as shown by sudden and severe pain, followed by cold sweat, shock, vomiting, thirst, tympany, rapid breathing, etc. Dr. Gaines and I made an autopsy, which revealed diffuse peritonitis, much lymph in all parts of the abdomen, and more than a pint of serous fluid.

A perforation through which a pencil could easily be passed was found in the anterior wall of the stomach, near the greater curvature. Immediately under and corresponding with this, was a persimmon seed, whose edge projected above the surface of the concretion, and which, doubtless, was the cause of it. The prominence of this seed is not marked now like it was before the great shrinkage the calculus has undergone.

In the stomach was found much, perhaps several ounces, of a yellowish white substance, resembling curd. Some of this had escaped into the abdominal cavity.

Examining the mucus membrane, through the incision made for removing the mass, several small shallow erosions were found.

The stomach was so distended that when lightly filled with lint its displacing capacity was twenty-six ounces. Its walls were proportionately thin.

The pyloric constriction, or orifice, was entirely obliterated, it being impossible to make out the line of demarcation between the stomach and duodenum. Doubtless this was caused by the impinging of the smaller end of the concretion during the frequent vomiting.

This gastrolith, when fresh, was a most perfect cast of the normally-shaped stomach, and was made up mainly of persimmon seeds, pulp and peel, together with starchy matter. It was quite unlike what you now see.

One who saw it then would hardly recognize it now, being so much smaller. The unequal shrinkage of its constituent parts has made its surface uneven. It was five and three-quarter inches long. Its pyloric diameter was one and one-quarter inches, while its greatest (near the cardia) was one and three-quarters. Its weight has diminished from seven and one-half to one and one-half ounces.

Research in the surgeon general's office reveals the fact that at the time it was reported it, too, was unique. Two years later Dr. Oliver, of Cincinnati, reported a similar case of gastrolith before the meeting of the A. M.

A., 1902. His case was published in the journal of the A. M. A., Oct. 4, 1902.

These three cases prove that eating persimmons is liable to be followed by a condition that, though rare, is far more serious than the consequent indigestion that is occasionally observed. It is fair to presume that such cases have occasionally occurred ever since man began to eat this fruit, but that correct diagnoses were not made before the days of exploratory incisions.

As seeds were the constituents of the three concretions it may be surmised that if they be not swallowed the fruit may be eaten with impunity. This presumption is strengthened by the rarity of such liths notwithstanding the very common eating of this fruit, the seeds usually not being swallowed.

Two of the cases having occurred in children, who are less careful about what they swallow, help to this conclusion. It is surprising that such a large and hard foreign body remained in the stomachs for several weeks without more impairment of the general health.

In the case of the enterolith it is probable that originally it too was a gastrolith, and that after about a week it escaped into the intestine and by mechanical irritation caused the diarrhea at that stage. Its small size made the escape through an adult pylorus possible, but not so of the two much larger gastroliths in the stomachs of children.

In the case of the enterolith there were no symptoms during the week following the ingestion of the fruit, the diarrhea being the first.

As the intestinal lumen was completely occluded by it, it was impossible that it could have been in the intestine a week without symptons. The most remarkable fact connected with the subject is that two of the only three cases reported have occurred in the practice of an obscure "Arkansaw Doctor."

Note 1.—The interest that attaches to these concretions is increased by the fact that at the same meeting before which I reported the case of enterolith, Dr. A. M. Smith, of Cherokee, Kan., reported a similar case and exhibited the gastrolith composed mainly of persimmons.

Note 2.—Very soon I shall present these specimens to the Army Medical Museum at Washington, D. C.